Enclosure 4

Attachment 4.19 D (4)

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Approval Date APR 0 4 2001
Effective Date 2/1/98

Plan # 98-001
Supersedes Plan # 97-001

OFFICIAL

State Plan Under Title XIX of the Social Security Act

State: Massachusetts

Institutional Reimbursement

APPENDIX A

114.2 CMR 6.00
Standard Payments to Nursing Facilities

Section
6.01: General Provisions
6.02: General Definitions
6.03: Standard Payments
6.04: 1998 Transition Payments
6.05: Rate Year Adjustments
6.06: Reporting Requirements
6.07: Special Provisions

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

ARGEO PAUL CELLUCCI
GOVERNOR

WILLIAM D. O'LEARY
SECRETARY

BARBARA ERBAN WEINSTEIN
COMMISSIONER

July 24, 1998

The Honorable William Galvin
Secretary of the Commonwealth
State House
Boston, MA 02133

Dear Mr. Secretary:

At its meeting of July 23, 1998, the Division of Health Care Finance and Policy adopted amendments to regulation 114.2 CMR 6.00: Standard Payments to Nursing Facilities, pursuant to M.G.L. c.118. A public hearing was held on these amendments on June 22, 1998.

Three attested copies of the amended regulation are attached for filing pursuant to M.G.L. c.30A, section 5. This letter is incorporated into the Division's finding and the statement of reasons thereof, pursuant to M.G.L. c.30A, section 2.

Very truly yours,

John A. Daley
Executive Secretary

JAD:afs

Attachments

Public Hearing - 6/22/98
Adopted - 7/23/98

No substitive changes that impact methodology or reimbursement
i.e. effect date remains 7/1/98

OFFICIAL

The Commonwealth of Massachusetts
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Attachments

OFFICIAL

114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
LONG-TERM CARE FACILITIES

114.2 CMR 6.00: STANDARD PAYMENTS TO NURSING FACILITIES

Section

6.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 6.00 governs the rates of payment effective February 1, 1998 for services rendered to Publicly-Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

ACE Group. The Audit, Compliance and Evaluation Group of the Division of Health Care Finance and Policy.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units which may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical,; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs. For facilities organized as sole proprietors or partnerships and for which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits, administrative and general costs shall include an imputed value of $69,781 to reflect the costs of such services.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building. The structure that houses residents. Building Costs include the direct cost of construction of the shell and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures that are made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

6.02: continued

Capital Costs. Capital Costs include Building Depreciation, Long Term Interest Expense, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of ten categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A *bona fide* transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to such larger items as the Building.

Hospital-Based Nursing Facility. A separate Unit or Units located in the hospital building licensed for both hospital and Long-Term care services which comprise less than a majority of the facility's total licensed beds. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, *et seq.*

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

6.02: continued

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility which increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes which have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) that are necessary to obtain Long-Term financing through a mortgage, bond or other Long-Term debt instrument.

New Facility. A Nursing Facility that opens on or after February 1, 1998. A Replacement Facility is not a New Facility.

Non-Profit Provider. A Provider either organized for charitable purposes or recognized as a non-profit entity by the Internal Revenue Service. It includes Massachusetts corporations organized under M.G.L. c.180; tax exempt clubs, associations, organizations, or entities; corporations organized under M.G.L. c.156B and granted a 501(c)(3) tax exemption; and facilities owned or operated by governmental Units.

Nursing Costs. Nursing costs include the 1996 Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Workers Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, § 71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

6.02: continued

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that does not have a provider agreement with the Division of Medical Assistance to provide services to publicly-assisted Residents.

Proprietary Provider. A Provider that does not meet the criteria specified in the definition of "Non-Profit Provider."

Provider. A Nursing Facility providing care to Publicly-Aided Residents or Industrial Accident Residents.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly-Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The calendar year in which the standard payment rates are in effect.

Related Party. An individual or organization associated or affiliated with, or which has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility which existed prior to February 1, 1998 that replaces all of its beds and/or its entire building pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6).

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the 1996 cost reports.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility which has been licensed by the Department to provide residential care.

6.02: continued

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: Standard Payments

(1) Standard Payment Rates.

(a) There are standard payment rates for Nursing and Other Operating Costs:

Case Mix Category	Nursing	Other Operating
1	15.83	45.33
2	15.83	45.33
3	15.83	45.33
4	49.25	45.33
5	49.25	45.33
6	49.25	45.33
7	49.25	45.33
8	77.38	45.33
9	77.38	45.33
10	94.18	45.33

(b) New facilities which open in 1998 and Hospital-based Nursing Facilities will be paid at the Standard Payment Rates.

(2) Capital Payment.

(a) The payment for Capital Costs will be $17.29 per day for the following:

1. facilities which open in 1998 pursuant to Determination of Need approved after March 7, 1996;
2. replacement facilities which open in 1998 pursuant to a Determination of Need approved after March 7, 1996,
3. facilities which open in 1998 in Urban Underbedded areas which are exempt from the Determination of Need process;
4. new beds which become licensed in 1998 pursuant to a Determination of Need approved after March 7, 1996;
5. new beds which become licensed in 1998 and represent 12-bed expansion projects which are not associated with an approved Determination of Need project;
6. Hospital-Based Nursing Facilities, and,
7. Private Nursing Facilities which sign a Provider Agreement with the Division of Medical Assistance in 1998.

(b) The payment for Capital Costs will be calculated pursuant to 114.2 CMR 6.05(2) for the following:

1. facilities which open in 1998 pursuant to Determination of Need approved before March 7, 1996;
2. replacement facilities which open in 1998 pursuant to a Determination of Need approved before March 7, 1996;
3. for new beds which become licensed in 1998 pursuant to a Determination of Need approved before March 7, 1996;
4. facilities which are renovated in 1998 pursuant to an approved Determination of Need; and,
5. facilities which transfer Determination of Need approvals.

6.03: continued

(c) For beds licensed prior to 1998, the Capital Payment is determined based on the facility's Allowable Fixed Costs and Equity per diem amounts effective January 31, 1998 calculated pursuant to 114.2 CMR 5.00. If a facility's Allowable Fixed Costs and Equity or Use and Occupancy payments are greater than $17.29 per day, the facility's 1998 Capital Payment will be the greater of 90% of its 1997 Allowable Fixed Costs and Equity or Use and Occupancy payments or $17.29 per day. If a facility's Allowable Fixed Costs and Equity or Use and Occupancy payments are equal to or lower than $17.29 per day, the facility's 1998 Capital Payment will equal its 1997 Allowable Fixed Costs and Equity or Use and Occupancy payments.

(d) Facilities with licensed beds that were out of service prior to 1997 which re-open in 1998 will receive a Capital Payment of the lower of $17.29 per day or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.

(e) For facilities with beds licensed prior to 1998 that add new beds or renovate in 1998, the Division will calculate a blended capital payment rate based on the rates calculated under 114.2 CMR 6.03(2)(a), 114.2 CMR 6.03(2)(b), 114.2 CMR 6.03(2)(c) or 114.2 CMR 6.03(2)(d). Each capital rate will be weighted by the ratio of beds associated with that rate divided by total constructed capacity.

(f) New facilities and facilities which open new beds, renovate, or re-open beds in 1998 must file with the Division according to the requirements of 114.2 CMR 6.05(3).

(3) Ancillary Costs.

(a) General. For 1998, unless a Provider participates in the Ancillary Pilot Program under 114.2 CMR 6.03(3)(b), or a Provider's rates include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(b) Ancillary Pilot Program. A provider may apply to the Division of Medical Assistance to participate in an alternative Ancillary Pilot Program for payment of Ancillary Services. The Division of Medical Assistance will determine the standard payment amount and services to be included in the standard payment. . The Division of Medical Assistance will establish a deadline for Providers to file an application to participate in the program. The Division of Medical Assistance will notify the nursing facility industry of all relevant dates and application processes. All providers may apply to participate. The Division of Medical Assistance will select providers for participation such that there will be a representative sample of the nursing facility industry.

(4) Residential Care Beds. The Division will establish separate Nursing and Other Operating Costs payment rates for Residential Care Beds in a dually-licensed facility. The Division will determine the proportion of 1996 reported costs allocable to the rest home beds. It will exclude from the calculation reported costs for Ward Clerk, Utilization Review, Medical Records, and Advisory Physician. Allowable costs will be limited to the 1998 freestanding rest home ceiling established in 114.2 CMR 4.00. The facility's rate for Residential Care Beds will not exceed its 1998 Payment Rate for Case Mix Category 1 Nursing Facility Residents, and the rate will not be lower than its certified 1997 rate for Residential Care Beds. The Residential Care Bed rate is not subject to the Total Payment Adjustment ceiling under 114.2 CMR 6.04(4)(c)1.

(5) Special Provisions.

(a) New Facilities. New facilities which open in 1998 will be paid at the Standard Payment Rates for Nursing and Other Operating Costs.

(b) Beds Out of Service. Facilities with licensed beds that were out of service prior to 1997 which re-open in 1998 will receive the lower of the Standard Payment Rates or the most recent prior billing rates inflated to 1997 for Nursing and Other Operating Costs.

(c) Pediatric Nursing Homes. Payments for Nursing to facilities licensed to provide pediatric nursing facility services will be determined using 1996 Reported Costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be based on 1996 costs subject to a cap of $10.51. A pediatric nursing facility may apply to the Division for a rate adjustment for the otherwise unrecognized medical costs of residents over the age of 22 who were previously enrolled in the facility's Chapter 766 program. The Division will calculate an adjustment to include the reasonable costs for these services subject to approval by the Division of Medical Assistance.

6.03: continued

(d) Rates for Innovative and Special Programs. The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

1. The Provider has received prior written approval from the Executive Office of Elder Affairs to establish and maintain a program; or
2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

6.04: Rate Year 1998 Transition Payments

The 1998 Payment Rates are the sum of the 1998 Standard Payments for Nursing and Other Operating Costs, the Capital Payment rates, and 1998 Transition Payments for Nursing and Other Operating Costs; subject to the Total Payment Adjustment set forth at 114.2 CMR 6.04(4).

(1) Nursing Payment Rates. The Nursing Payment Rates are the sum of the Nursing Standard Payments set forth in 114.2 CMR 6.03(1) and the Nursing Transition Adjustment.

(a) Determination of Facility Rates. For each facility, the Division will calculate ten case mix adjusted nursing rates.

1. Allowable Nursing Cost per Management Minute. The Division will determine a facility's Allowable Nursing Costs as follows:

a. 1996 Actual Nursing Cost per Management Minute. A facility's Actual Nursing Cost per Management Minute is the sum of its reported Nursing Costs divided by the greater of (1) 96% of the current Licensed Bed Capacity for 1996 times 366 or (2) actual 1996 patient days, divided by the facility's 1996 average Management Minutes.

b. Determination of Nursing Ceiling. The Division will calculate a Nursing Ceiling based upon reported 1996 average nursing cost per management minute as follows:

i. The Division will calculate a nursing *per diem* for each facility by dividing the facility's claimed 1996 nursing costs by the greater of 1996 patient days or 96% of the Mean Licensed Bed Capacity in 1996 times 366.

ii. The Division will calculate the 1996 average nursing cost per Management Minute for each facility by dividing the 1996 nursing cost *per diem* by the facility's 1996 average Management Minutes.

iii. The Nursing Ceiling is 110% of the median claimed 1996 average Nursing Cost per Management Minute, or $.325 per Management Minute.

c. Allowable Nursing Cost per Management Minute. A facility's Allowable Nursing Cost per Management Minute is the lower of its 1996 Actual Nursing Cost per Management Minute or the Nursing Ceiling.

2. Calculation of Ten Nursing Per diem Rates. The Division will multiply the allowable nursing cost per management minute by the facility's average management minutes per case-mix category to obtain a per diem rate for each category. If the facility-specific mean minutes per case mix category equals zero, the Division will use the industry median minutes for that category.

3. Calculation of Weighted Nursing Per Diems for Four Nursing Payment Groups.

a. The Division will calculate weighted nursing per diems based on the four payment categories below:

Payment Group	Casemix Category
A	1 - 3
B	4 - 7
C	8 - 9
D	10

b. It will calculate the proportion of residents in each of the four payment groups by summing the casemix proportions for the categories in each of the four payment groups.

6.04: continued

c. It will calculate casemix weights within each payment group by dividing:
i. the casemix proportion for the casemix category, by
ii. the proportion of residents in its payment group from 114.2 CMR 6.04(1)(a)3.a..
d. For each casemix category, it will multiply the nursing per diem from 114.2 CMR 6.04(1)(a)3b by the casemix weight from 114.2 CMR 6.04(1)(a)3.c..
e. For each payment group, it will sum the casemix-weighted nursing per diems from 114.2 CMR 6.04(1)(a)3.d. to obtain four weighted nursing per diems.
f. It will multiply the four weighted nursing per diems by 5.12%.

(b) Nursing Transition Adjustment. The Nursing Transition Adjustments are the Facility Rates calculated pursuant to 114.2 CMR 6.04(1)(a) minus the Standard Payments for Nursing.

(2) Other Operating Cost Payment Rate. The Other Operating Payment Rate is the sum of the Standard Payment rate and the Other Operating Transition Adjustment.

(a) Determination of the Allowable Other Operating Costs. The Division will determine the facility's Allowable Other Operating Costs per diem as follows:

1. The Division will subtract the facility's reported 1996 Administrative and General expenses from reported 1996 Other Operating expenses to obtain Net Other Operating Expenses.
2. The facility's Net Other Operating Expenses per day is equal to Net Other Operating Expenses divided by the greater of:
   a. 96% of the mean Licensed Bed Capacity in 1996 times 366, or
   b. actual patient days.
3. The facility's Allowable Administrative and General per diem is equal to the lower of:
   a. reported 1996 Administrative and General expenses divided by the greater of:
      i. 96% of the mean Licensed Bed Capacity in 1996 times 366, or
      ii. actual patient days, or
   b. the Administrative and General ceiling of $10.51 per day.
4. The sum of the facility's Net Other Operating Expenses per day and its Allowable Administrative and General per diem equals the facility's preliminary Other Operating Cost per diem.
5. The Division will calculate an Other Operating Cost Ceiling as follows:
   a. The Division will calculate the 1996 Other Operating Cost per diems for all facilities.
   b. The Other Operating Ceiling equals the industry median plus 6%, or $50.21.
6. A facility's Allowable Other Operating Per Diem is the lower of its Other Operating Cost per diem and the Other Operating Ceiling.

(b) Other Operating Blended per diem. For 1998, the payment for Other Operating Costs is the sum of 66.7% of the facility's Allowable Other Operating Costs times 5.12% and 33.3% of the Other Operating Standard Payment.

(c) Other Operating Transition Adjustment. The Other Operating Transition Adjustment is the difference between the Other Operating Blended per diem and the Other Operating Standard Payment.

(3) Preliminary 1998 Payment Rates. The preliminary 1998 payment rates are the sum of the 1998 Standard Payments for Nursing and Other Operating Costs, the Capital Payment rate and the 1998 Transition Payments for Nursing and Other Operating Costs. For hospital-based nursing facilities, the preliminary 1998 payment rates are the sum of the 1998 Standard Payments for Nursing and Other Operating Costs and the Capital Payment of $17.29 per day.

(4) Total Payment Adjustment. There is an additional adjustment to reflect the percentage change from the facility's 1998 weighted preliminary payment rates and its weighted current payment rates.

(a) Current Payment Rates. A facility's current payment rates are its most recently certified rates effective December 1, 1997 calculated pursuant to 114.2 CMR 5.00. It includes certified 1997 administrative adjustments. The Division will amend a facility's 1998 payment rates to reflect 1997 amended rates pursuant to 114.2 CMR 6.05(1).

6.04: continued

(b) Calculation of Weighted Rates. The Division will calculate weighted 1997 rates as follows:

1. Using third quarter 1997 case mix proportions, calculate the "weighted current payment" as the sum of the products of each category's current payment by its corresponding case mix proportions.
2. Using third quarter 1997 case mix billing data, calculate the "weighted preliminary payment" as the sum of the products of each category's preliminary 1998 payment rate by its corresponding case mix proportions.
3. Calculate the percentage difference from the "weighted current payment" to the "weighted preliminary payment".

(c) Total Payment Adjustment.

1. If the percentage increase between a facility's 1998 weighted preliminary payment as calculated above and its 1997 weighted current payments is greater than 9%, the facility's rate adjustment from its current billing rates will be limited to 9%.
2. If the facility's 1998 weighted preliminary payment as calculated above is lower than the facility's 1997 weighted current payment, the facility's 1998 rates will equal its 1997 rates.

(d) Special Provisions. The Total Payment Adjustment will not be recalculated as a result of Rate Year Adjustments made to Capital Payments Rates under 114.2 CMR 6.05(2).

6.05: Rate Year Adjustments

(1) Retroactive Adjustments. The Division will retroactively adjust rates in the following situations:

(a) Facilities which did not file a 1996 Cost Report. If a facility operational in 1996 did not file the 1996 cost report, the facility will be paid at the lower of its current billing rates or the standard payment rates. If the facility does not file a 1996 cost report by May 1, 1998, the facility's rates will be lowered by 5%. If the facility does not file a 1996 cost report by July 1, 1998, the Division may terminate the facility's rates. If the facility files a 1996 cost report, the Division will calculate amended 1998 rates using the facility's 1996 cost report. The amended rate will be effective on the first day of the month following the receipt of an acceptable cost report. If the facility demonstrates that it cannot complete a 1996 cost report, it will continue to be paid at its current billing rates or it may request that the Division use a different base year cost report to determine its rates.

(b) Facilities that opened in 1997. A facility that opened in 1997 will receive its 1997 billing rates until a 1997 cost report is received. The Division will calculate the facility's 1998 rates using 1997 base year costs subject to cost ceilings updated to 1997. The cost adjustment factor to update Nursing and Other Operating Costs will reflect the change from 1997 to 1998. For facilities with lookback rates receiving divisor relief pursuant to 114.2 CMR 5.11, the Division will extend the divisor relief in the 1998 rate for the twelve months allowed but not beyond that point. After the divisor relief expires, the Division will recalculate the facility's 1998 capital payment based on constructed capacity.

(c) Amended 1997 Rates. The Division will amend 1998 rates to reflect 1997 amended rates for the following: offbase and lookback rates pursuant to 114.2 CMR 5.11, administrative adjustments pursuant to 114.2 CMR 5.12, amended rates pursuant to an administrative appeal; amended DON approvals for Maximum Capital Expenditures if the original Determination of Need was approved prior to March 7, 1996, or any further adjustments to 1997 rates to reflect the results of any desk or field audits conducted by the Division or the Division of Medical Assistance.

(d) Mechanical Errors. The Division may adjust rates if it learns that there is a material error in the rate calculations.

(e) Errors in the Cost Reports. The Division may adjust rates if it learns that the Provider has made a material error in the cost report.

6.05: continued

(2) Calculation of Capital for New Facilities, Newly-Licensed Beds, and Renovated Facilities. The Division will calculate Allowable Fixed Costs and Equity or Use and Occupancy according to 114.2 CMR 6.05(2)(c) and 114.2 CMR 6.05(2)(d) for facilities which open in 1998 pursuant to a Determination of Need approved before March 7, 1996, for new beds which become licensed in 1998 pursuant to a Determination of Need approved before March 7, 1996, and for facilities which are renovated pursuant to an approved Determination of Need. Payment for Capital Costs will be determined pursuant to 114.2 CMR 6.05(2)(e).

(a) Allowable Basis of Fixed Assets. The Allowable Basis of Fixed Assets is used to calculate allowable depreciation, interest, equity, and use and occupancy.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.

2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis.

b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976 and 1993 forward. In addition, the seller's allowable Building Improvements will become part of the Allowable Building Basis of the new owner.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates. The seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership, increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

6.05: continued

(b) Allowable Fixed Costs. The Division will calculate Allowable Fixed Costs including depreciation, interest, real estate taxes, Building insurance and Equipment rental as defined below:

1. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

2. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets.

a. Methodology. Allowable Depreciation is calculated using the straight line method.

b. Useful Lives. Except as provided below, Allowable Depreciation is calculated using the following useful lives:

ASSET	TYPE	USEFUL LIFE	DEPRECIATION RATE
Building	Class I or II as classified by the Department of Public Safety	40	2.5%
	Class III or IV as classified by the Department of Public Safety	33	3.0%
	A Building owned and operated by a political subdivision of the Commonwealth or an authority or which was financed by municipal bonds.	20	5%
Building Improvements	Building or leasehold Improvements made subsequent to the beginning of the Rate Year must be pro-rated over the life of the lease or the balance of the estimated life of the Building as determined above, but in no case to exceed the yearly rate of 5%.	Various	up to 5%
Equipment , Furniture and Fixtures		10	10%
Motor Vehicle Equipment		4	25%
Software		3	33.3%

3. Long Term Interest Expense.

a. Reimbursable Debt. Subject to the limitations on refinancing set forth in 114.2 CMR 6.05(2)(b)3.b., the Division will recognize a long term debt as reimbursable if it is obtained to finance assets used in the care of publicly-assisted patients and if it is supported by allowable depreciable fixed assets.

i. In order for the interest related to the financing of a newly acquired fixed asset to be recognized, the acquisition and financing must occur concurrently, except that a grace period of not more than 90 days between the date of acquisition and financing is permitted if the Provider can present sufficient documentation to support its claim that all reasonable attempts were made to finance the asset at the time of the acquisition.

ii. The Division will not allow interest expense on loans to the facility from an owner, officer, or Related Party.

iii. The Division will not offset interest income against interest expense.

6.05: continued

iv. Mortgage Acquisition Costs. Mortgage Acquisition Costs must be amortized over the life of the mortgage. Amortized mortgage acquisition costs are treated as Long Term Interest Expense. Mortgage Acquisition Costs are subject to the provisions of maximum interest rates and permanent factors, if applicable.

b. Refinancing. The Division will recognize the refinancing of an existing allowable debt as an allowable debt under the following circumstances:

i. Crossover. When the accumulated principal payments on the existing, allowable debt exceeds the accumulated depreciation allowed by the Division on the allowable fixed assets which have been financed by that debt; or

ii. Demand Note. When an existing, allowable debt becomes payable upon demand; or

iii. Lowered Expense. When the Long-Term Interest Expense over the life of the refinanced debt is lower than it would have been under the remainder of the existing, allowable debt. The Provider must submit comparative schedules showing total Long-Term Interest Expense under both the existing, allowable debt and the re-financed debt.

iv. Financing of Allowable Additions. When a Provider refinances for amounts greater than the existing, allowable debt and the additional indebtedness is used for a significant addition of allowable depreciable fixed assets. If the refinancing is for amounts greater than the existing, allowable debt on the date of the refinancing and the additional indebtedness is used for purposes other than a significant addition of allowable depreciable fixed assets, the Division will not recognize interest expense on the additional indebtedness. When a Provider refinances for amounts greater than the existing, allowable debt on the date of refinancing and the additional indebtedness is used for the addition of allowable depreciable fixed assets which are not significant, only the portion of the refinancing related to the financing of the newly acquired fixed assets will be allowable.

c. Non-recognized Debt. If the refinanced debt is not allowable, the Division will continue to include in the rates the amount of Long Term Interest Expense which would have been incurred on the prior allowable debt. The Division will include the lower of the interest which would have been incurred or the actual Long-Term Interest Expense actually incurred by the Provider.

d. Permanent Factor for Interest. The Division will recognize interest on an allowable debt to the extent that such debt is supported by depreciable fixed assets. Land and Mortgage Acquisition Costs are not depreciable fixed assets. The Division will calculate the percentage of allowable debt to total debt by dividing the allowable basis of depreciable fixed assets by the total amount of the reimbursable debt. Upon refinancing, the Division will recalculate the Permanent Factor by dividing the prior allowable mortgage balance by the total amount of the new debt.

e. Allowable Interest Rate. The allowable interest rate is the lower of the percentage of total Long-Term Interest Expense divided by the average outstanding principal during the reporting period, or the annual percentage rate on special issues of the public debt obligations issued by the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing was incurred plus 3%. The allowable interest rate applies throughout the life of any debt and will continue to apply if the Provider refinances an allowable debt which is not recognized under 114.2 CMR 6.05(2)(b)3.c..

(c) Calculation of Allowable Fixed Costs per diem:

1. The Division will calculate total Allowable Fixed Costs by adding allowable depreciation, allowable Long Term Interest Expense, Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment; the Non-Income portion of the Massachusetts Corporate Excise tax; Building Insurance; and Rental of Equipment located at the facility.